STATE OF VERMONT

HUMAN SERVICES BOARD

In re	)	Fair Hearing No. 20,816
	)	
Appeal of	)	

INTRODUCTION

The petitioner appeals a decision by the Office of Vermont Health Access (OVHA) denying her request for comprehensive orthodontia for her son under Dr. Dynasaur. The issue is whether the son's condition meets the medical necessity criteria for the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program. The following recommendation is based upon testimony, stipulated exhibits, and written argument by the parties.

FINDINGS OF FACT

1. The petitioner has a twelve-year-old son, C.L. The petitioner was referred by her family dentist to Dr. F.Z., an orthodontist, regarding C.L.'s need for orthodontia. Dr. F.Z. examined C.L. on or about February 1, 2007.[1] Dr. F.Z. made diagnostic casts or impressions, photographed C.L.'s mouth, and took both panorex and cephalometric x-rays. Dr. F.Z. recommended comprehensive orthodontics.

[1] Petitioner's son was 11.5 years old when the authorization was first sought.

2. On March 22, 2007, Dr. F.Z. submitted a Medicaid Request for Prior Authorization for orthodontic treatment on the form then used by OVHA.[2] On that form, he checked two of the minor criteria, namely, (1) two blocked cuspids[3] per arch (deficient by at least 1/3 of needed space) and (2) open bite 4+ teeth, per arch. He also checked Angle Class II[4] and noted a 3 millimeter (mm) overbite, a 4 mm overjet, and 8 mm crowding. Dr. F.Z. did not check other handicapping malocclusion or special medical consideration on the prior authorization form. He included the February 1, 2007 diagnostic materials with his request.

3. Dr. J. R. is a dental reviewer for OVHA; he reviewed the prior authorization request including the diagnostic materials. On March 27, 2007, OVHA denied the request for comprehensive orthodontics. Dr. J.R. determined that there was only one blocked cuspid and that there was not an open bite of 4+ teeth per arch.

4. Petitioner appealed the denial on March 29, 2007.

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[2] This form has been superseded by a Prior Authorization form that is more in line with the requirements of Jacobus v. Department of PATH, 177 Vt. 496 (2004).

[3] Cuspids are the third tooth from the left and right of the midline and are commonly known as canine teeth. They are between the incisors and the bi-cuspids (premolars).

[4] In Angle Class II, the lower first molar is posterior to the upper first molar and the upper front teeth project further forward.

5. Petitioner appeared at a hearing held on April 26, 2007. The petitioner testified her son's teeth look like "Billy Bob" teeth. Petitioner brought with her the impressions, pictures and x-rays that Dr. F.Z. submitted with the request for prior authorization. Petitioner testified that her son wears a retainer that his family dentist gave him about one year ago. Petitioner stated that she was told by her family dentist one year ago that C.L. needed braces but that they needed to wait until C.L. had more of his adult teeth. Petitioner described a deep vertical overbite that could damage her son in the future. Petitioner explained that C.L. takes out the retainer when he eats because he finds it easier to eat without the retainer. Petitioner explained that C.L. had difficulty chewing. She described an incident one day when she found C.L. crying in his bedroom because his mouth hurt. Petitioner testified that she saw cuts on the palate of C.L.'s mouth caused by the overbite. According to petitioner, her son has bled on occasion from biting his palate. Petitioner pointed to ridges on the palate of the impression that were about 1/2 inch from his teeth; petitioner said the ridges were evidence of cuts from the overbite. Petitioner testified that C.L. does not smile because he is embarrassed. Petitioner submitted into

evidence a letter dated March 19, 2007 from Dr. F.Z. The record was kept open to allow OVHA an opportunity to review the letter and for Dr. J.R. and Dr. F.Z. to consult.

6. The March 19, 2007 letter is from Dr. F.Z. to the petitioner and describes the reasons for orthodontic treatment as a deep vertical overbite and severe crowding in both arches. The reasons in the March 19 letter vary from the reasons in the request for prior authorization.

7. Dr. J.R. reviewed the March 19, 2007 letter and conferred with Dr. F.Z. On May 16, 2007, Dr. J.R. updated OVHA's dental basis statement and concluded that C.L.'s condition was not severe enough to authorize orthodontics. Dr. J.R. did not receive any information from the March 19, 2007 letter or from his conversation with Dr. F.Z. that changed his original opinion.

8. Petitioner obtained legal representation on or about May 18, 2007. A telephone status conference was held on June 22, 2007 in which the petitioner's counsel indicated they were seeking a second opinion. At the next telephone status conference held on July 20, 2007, petitioner's counsel reported that C.L. had been seen by Dr. F.S. on July 9, 2007 but that Dr. F.S. had not received C.L.'s dental records at the time of the appointment. Dr. C.L. had scheduled a

follow-up appointment for September 10, 2007. The parties agreed to a September 18, 2007 telephone status conference. At the September 18, 2007 telephone status conference, the petitioner's counsel indicated that Dr. F.S. felt that C.L.'s condition met the criteria for orthodontic treatment. Arrangements were made for petitioner to send Dr. F.S.'s information to OVHA for review with a backup date of October 25, 2007 for testimony from the respective expert witnesses if the case did not resolve.

9. Petitioner submitted to OVHA a questionnaire dated October 5, 2007 from Dr. F.S. Dr. J.R. reviewed the information and issued an updated dental basis statement on October 18, 2007 that C.L.'s condition was not severe enough to warrant Medicaid payment for orthodontics. The information in the questionnaire and OVHA's response will be more fully set out as part of the testimony of Dr. F.S. and Dr. J.R. from the October 25, 2007 hearing. Both orthodontists testified by telephone.

10. Dr. F.S. has been an orthodontist in private practice since 1975. He practices in both Vermont and New Hampshire.

11. Dr. J.R. has been an orthodontist in private practice since 1967. He became board certified in 1993. Dr.

J.R. has worked for the past four years with the Vermont Department of Health, Dental Division, as a consultant reviewing Medicaid prior authorization requests for orthodontics. Dr. J.R. is also a member of the Vermont Child Health Services Cleft Palate Team.

12. Both Dr. F.S. and Dr. J.R. agree to certain facts. Their areas of agreement include:

1. C.L. has one blocked cuspid (T3) deficient by 1/3 of the needed space on the lower left of his mouth.

2. They both used the impressions, x-rays, and pictures from Dr. F.Z. They agree that the impressions are excellent.

3. C.L. has Angle Class II.

4. It is optimal to do orthodontic treatment while the patient is still growing.

5. Cuspids are the most important teeth because they have the strongest root and protect other teeth from the forces of chewing.

6. Judging crowding is somewhat subjective.

7. The boley gauge is a more accurate measure than a caliper millimeter ruler.

13. Dr. F.S. testified that he examined C.L. on two occasions. He examined C.L. on July 9, 2007 and September 10, 2007.

Dr. F.S. testified that it helps to physically examine a patient because the diagnostic impressions and x-rays show a

moment in time. He pointed to a change in C.L.'s crossbite involving his right bicuspid as an example in which a change had occurred between the February 1 diagnostic materials and the September 10 appointment.[5]

Dr. F.S. described C.L.'s lower jaw as being significantly smaller than his upper jaw. If untreated, the upper jaw will continue to push the lower jaw further back.

According to Dr. F.S., C.L.'s lower left cuspid and lower right bicuspid were blocked out by at least 1/3 of the needed space. According to Dr. F.S., the idea is to accommodate the cuspid and bicuspid in the same arch without extraction. Dr. F.S. gave his opinion that the blocked cuspid and blocked bicuspid in combination with crowding and cross-bite are equivalent to the minor criteria of two blocked cuspids. In his questionnaire dated October 5, 2007, Dr. F.S. includes the other three cuspids as blocked by at least 1/4 of the needed space.

Dr. F.S. noted C.L.'s anterior open bite. He stated that the February 1 model and x-rays showed that the six teeth in the upper arch (from right cuspid to left cuspid)

[5] Cross-bites lead to thinning of tissue in the area of the cross-bite. With orthodontia, the cross-bite can be corrected and the thinning of tissue addressed.

are not in contact with the corresponding teeth in the lower arch.

Dr. F.S. testified that C.L.'s rear teeth were hyper-functioning while his anterior (front) teeth were hypo-functioning. He explained that teeth that hypo-function over time can lead to atrophy of tissue and bone.

Further, Dr. F.S. stated that C.L. met the minor criteria for crowding. Crowding makes it more difficult for a person to maintain his/her oral hygiene and prevent future problems. Dr. F.S. used a caliper millimeter ruler to measure the crowding. He explained that the measurements include a measure of subjectivity depending on how you position the ruler; he stated that the measures may be off by .5 mm in either direction.

At hearing, Dr. F.S. stated that C.L. had 10 mm of crowding in his upper jaw and 16 mm of crowding in his lower jaw. In his written materials, Dr F.S. wrote that C.L. had crowding of 10-12 mm per arch. The inconsistency between the measures in written and oral testimony was not adequately explained at the hearing. The original measures by Dr. F.Z. were 8 mm of crowding which he characterized as severe crowding in the March 19, 2007 letter to petitioner. Dr. J.R.'s measurements included 8 mm of crowding for the lower

arch and a bit less for the upper arch. It is more likely that the measure for crowding is the original measurement of 8 mm per arch.

Dr. F.S. testified that the optimal time for orthodontic treatment is while the patient is still growing. In particular, he believes that the best time for a male is from eleven to thirteen years of age. He testified that if you wait to do orthodontia once C.L. has grown, there is a potential that C.L. may need extractions or surgery.

He also felt that temporal mandibular joint problems (TMJ) are possible due to current problems in C.L.'s bite such as the lack of contact with the front teeth and the hyper-function of the back teeth. However, Dr. F.S. testified that the etiology of TMJ is multi-factorial and that individuals with malocclusions may not develop TMJ whereas individuals with properly aligned teeth may develop TMJ. The link between C.L. and potential TMJ is too attenuated to be considered a potential consequence for C.L.

Dr. F.S. testified that he sought a second opinion from New Hampshire's Medicaid dental consultant before submitting his opinion that C.L. met the Medicaid criteria. Based on that consultation, Dr. F.S. went ahead with his recommendations.

14. Dr. J.R. testified that C.L. has some crowding, some open bite, and vertical growth pattern, but that C.L. does not meet the minor criteria set out on the prior authorization form.

Dr. J.R. used the "four corners" of the prior authorization form as his guide when he reviewed C.L.'s documentation. As a result, Dr. J.R. did not look at whether C.L.'s materials met the M100 EPSDT criteria or included dental problems that were equivalent in severity to the minor criteria.

Dr. J.R. testified that the ceph x-ray includes the skull and documents whether there is still potential for the patient to grow and develop. C.L.'s ceph documented that C.L. is still growing and developing. Dr. J.R. testified that boys grow until age 18 years, and, in some instances, until 21 years. Dr. J.R. testified that there is still time to treat C.L. before he reaches adult physical growth.

Dr. J.R. testified that bicuspids are not on the form so he did not look at them. Dr. J.R. testified that based on the prior authorization form, one blocked cuspid and one blocked bicuspid are not the equivalent of two blocked cuspids. He called the bicuspids the weakest teeth in the

mouth and did not believe they would impact the functioning of the cuspid.

Dr. J.R. described an open bite as an area where the teeth do not vertically overlap. He testified that he looked at the molds and how they fit together. He saw three teeth in an open bite—one cuspid and two lateral incisors.

Dr. J.R. was asked whether an in-person examination of a patient would be more accurate than a review of the impressions and other diagnostic tests. Dr. J.R. testified that the impressions can be more accurate than observation. As an example, he testified that bite marks on the roof of the mouth would show up on the model but may be missed by observation.

Dr. J.R. testified that crowding is an overlap of teeth. He used a boley gauge on the model to measure the crowding. The boley gauge measures tenths of millimeters and is steadier than a caliper ruler. He testified that he found 8 mm crowding on the lower arch and less on the upper arch.

ORDER

OVHA's decision to deny prior authorization is reversed.

REASONS

Statutory and Regulatory Requirements

Medicaid is a cooperative federal-state program in which participating states must comply with certain federal requirements. Cushion v. Dep't of PATH, 174 Vt. 475 (2002)(mem.), Jacobus v. Department of PATH, 177 Vt. 496 (2004). One such requirement is the Early and Periodic Screening, Diagnosis and Treatment provisions of the Medicaid Act that covers children less than twenty-one years of age. 42 U.S.C. §§ 1396a(a)(10)(A) and 1396d(4)(B).

States are required to provide dental services under EPSDT. Dental services are defined at 42 U.S.C. § 1396d(r)(3) to include services:

> (B) which shall at a minimum include relief of pain and infections, restoration of teeth, and maintenance of dental health.

See also 42 C.F.R. § 441.56, Centers for Medicare and Medicaid Services (CMS) State Medicaid Manual § 5122(C), page 5-9. Orthodontia is a dental service that utilizes prosthetic devices that can "prevent or correct physical deformity or malfunction". 42 C.F.R. § 440.120(c)(2).

The federal government has taken special care to address the needs of children. Rosie D. v. Romney, 410 F.Supp.2d 18 (D.Mass. 2006). In doing so, the federal government stresses

early detection and treatment in order to avoid more costly treatments for health problems that may become more complicated over time. S.D. ex rel. Dickson v. Hood, 391 F.3d 581 (5th Cir. 2004); Semerzakis v. Commissioner of Social Services, 274 Conn. 1 (2005). See also CMS State Medicaid Manual § 5010(B), page 5-3.

To meet EPSDT requirements, Vermont has adopted regulations found at M622 which include these provisions:

> M622.1 Definition
>
> Medically necessary orthodontic treatment involves the use of one or more prosthetic devices to correct a severe malocclusion.
>
> M622.4 Conditions for Coverage
>
> To be considered medically necessary, the beneficiary's condition must have one major or two minor malocclusions according to diagnostic criteria adopted by the department's dental consultant or if otherwise necessary under EPSDT found at M100. (emphasis added)

In addition, the medical necessity criteria at M107 specifically state that services for EPSDT recipients are medically necessary when there is "a determination that a service is needed to achieve proper growth and development or prevent the onset or worsening of a health condition."

The Impact of the *Jacobus* Decision

The Jacobus case found that PATH[6] violated the comparability provisions of the Medicaid Act by using more onerous standards under M100 (EPSDT) than the listed criteria developed under M622. The Court noted on page 500 that "PATH's own dental consultants estimate that ninety per cent of children who are approved under the criteria for orthodontic treatment do not actually have 'handicapping malocclusions'."

The Court ruled PATH was mandated by EPSDT to make individualized reviews for recipients rather than rely solely on the listed criteria. Chappell v. Bradley, 834 F.Supp. 1030 (N.D.Ill. 1993). Moreover, the independent review needed to consider whether a recipient's condition was as severe as PATH's criteria. The Court stated on page 502:

> Reapplying individual criteria, without any analysis of cumulative impact, is not a consideration of all the factors relevant to a patient's condition.

It should be noted that the major and minor criteria used by OVHA have remained the same.

To start the independent review process, the treating orthodontist completes a Prior Authorization Request Form.

[6] PATH became the Department for Children and Families.

This form asks for the following diagnostic treatment criteria:

Major Criteria	Minor Criteria
Cleft palate	1 impacted cuspid
2 impacted cuspids	2 blocked cuspids per arch (deficient by at least 1/3 of needed space)
Severe Cranio-Facial Anomaly	3 congenitally missing teeth per arch (excluding third molars)
	Open bite 4+teeth, per arch
	Crowding per arch (10+mm)
	Anterior crossbite (3+teeth)
	Posterior crossbite (3+teeth)
	Traumatic deep bite impinging on palate
	Overjet 8+mm (measured from labial to labial)

Eligibility for comprehensive orthodontic treatment requires that the malocclusion be severe enough to meet a minimum of **1** major or **2** minor diagnostic criteria.

The form then includes space for Other Handicapping Malocclusion and Special Medical Consideration to be completed by an orthodontist or medical provider not associated with the treating orthodontist.

But, the form does not ask the referring orthodontist whether he/she believes the child's conditions are "equal to or greater than the severity of the listed criteria". By not

asking this question, OVHA is not eliciting the type of information required by the Jacobus decision.

One can question whether the form's language meets the spirit of the Jacobus decision. But, more importantly, OVHA's actions do not comport with the spirit of the Jacobus decision to look at the cumulative impact of the recipient's dental condition and see whether they are equivalent to the conditions in OVHA's major and minor criteria.

Applying EPSDT criteria to C.L.

Dr. J.R. testified that he did not look beyond "the four corners" of the document when reviewing C.L.'s diagnostic materials nor when reviewing Dr. F.S.'s written submissions. He couched his disagreement with Dr. F.S. by referring to the language of the minor criteria. Dr. J.R. did not do an independent review consistent with consideration of the cumulative nature of C.L.'s malocclusions and whether they were equivalent to the minor criteria.

Dr. J.R.'s testimony with its narrow focus on the specifics of the minor criteria stands in contrast to Dr. F.S.'s approach to look beyond the wording of the minor criteria to the cumulative impacts of (1) one blocked cuspid and one blocked bicuspid, (2) open bite, (3) crowding, and (4) the relationship of the upper jaw to the lower jaw and

the effects upon the functioning of the rear and anterior teeth.

Petitioner requests that the Board reverse OVHA's decision because the form did not elicit all pertinent information. Petitioner points to footnote one in Fair Hearing No. 19,476 that states the Board "may reverse these cases on procedural grounds if the Department fails to elicit all pertinent information, including opinions, from recipient's treating sources in a timely manner." In that case, the Hearing Officer intervened and wrote out the standard for the petitioner to take to the orthodontist for further information. The forthcoming information did not provide sufficient information for petitioner to make a prima facie case and switch the burden of persuasion to the Department to rebut.

Here, petitioner was able to obtain information whether petitioner's child had a condition equal or greater in severity to the listed criteria for OVHA to consider. The case does not rise to the level of reversing OVHA on procedural grounds.

OVHA mistakenly argues that the standard of review should become abuse of discretion in prior authorization cases. Fair Hearings arising under 3 V.S.A. are evidentiary

in nature and contemplate de novo review.[7] In Re Bushey-Combs, 160 Vt. 326 (1993), K.G. v. Dept. of Social and Rehabilitation Services, 171 Vt. 529 (2000). Fair Hearing Rule 11 places the burden of proof upon the agency in cases where benefits are being reduced or terminated. Otherwise, the burden of proof is placed upon the petitioner. If the petitioner makes a prima facie case, the agency is given the opportunity to rebut. This has been the standard in innumerable prior authorization cases. In the context of orthodontia cases, see Fair Hearing No. 19,476.

Petitioner argues that her son's condition either meets two minor criteria or is equivalent in severity to the minor criteria. Petitioner's evidence includes:

1. Deep vertical overbite based upon the testimony of petitioner, Dr. F.S., and statement in March 19, 2007 letter from Dr. F.Z.

2. Open bite based upon prior authorization form completed by Dr. F.Z. noting 4+ teeth per arch and testimony from Dr. F.S. noting 6 teeth overbite per arch. The minor criterion is 4+ teeth per arch.

3. Blocked cuspids based upon prior authorization form completed by Dr. F.Z. that two cuspids per arch were blocked by at least 1/3 of needed space, the testimony from Dr. F.S. of one blocked cuspid and blocked bicuspid as the equivalent of two blocked cuspid, and written information from Dr. F.S. that

[7] There are certain cases in which a statute or regulation specifically sets out an abuse of discretion standard. However, this is not the case here.

the other cuspids are blocked by 1/4 of needed space. The minor criterion is 2 blocked cuspids per arch.

4. Crowding based upon prior authorization form completed by Dr. F.Z. noting 8 mm of crowding, letter from Dr. F.Z. characterizing the crowding as severe.

5. Crossbite based on testimony from Dr. F.S. that C.L. developed a crossbite involving his right bicuspid in the intervening time from his submission for orthodontia on February 1, 2007 to September 10, 2007.

6. Cuts on palate and pain based upon petitioner's testimony of her observations of her son.

OVHA has pointed out the differences between Dr. F.S.'s testimony from the testimony of Dr. J.R. or from the written materials from Dr. F.Z. in order to question Dr. F.S.'s credibility.[8] To be accurate, there are differences between all three orthodontists which only underscores that diagnosis is as much of an art as a science. Dr. F.S. alluded to the subjective nature of his profession. Dr. F.S. also sought a second opinion before submitting his findings.

[8] The parties were given a briefing schedule after the October 25, 2007 hearing. Due to delays in the parties having the hearing transcribed, OVHA did not submit their brief until December 20, 2007. In their brief, OVHA asked the hearing officer to take judicial notice of a collateral proceeding involving Dr. F.S. Petitioner was not given advance notice of this request. Both parties had the opportunity to voir dire the experts at the fair hearing. If OVHA wanted to question Dr. F.S. on this collateral matter, the information was available to them prior to the fair hearing. The Hearing Officer declines to take judicial notice and notes for the record that the information would not have an impact on the outcome of this case.

Dr. F.S.'s approach includes looking at every conceivable possibility. To the extent that a particular possibility is attenuated such as the possibility of TMJ, that possibility is not considered as a basis for this decision. In looking at the approaches of Dr. F.S. and Dr. J.R., Dr. F.S. has been too broad and Dr. J.R. has been too narrow. But, the decision as spelled out below is based upon the evidence adduced at hearing and its application to the applicable legal standard.

Petitioner sustained her burden of making a prima facie case that her son meets the medical necessity standard for orthodontia. The burden of persuasion shifted to OVHA to rebut petitioner's case.

Dr. J.R. testified that C.L. had a deep vertical overbite, crowding of 8 mm in the lower arch and a bit less crowding in the upper arch, and an open bite of three teeth per arch. Dr. J.R. considered his responsibility to determine orthodontia requests based upon the criteria of the prior authorization form alone. He continued to do so at hearing. There was no explanation of the cumulative impact of C.L.'s individual factors and whether the cumulative impact was as severe as the listed criteria.

This decision is based upon the cumulative impact of C.L.'s deep vertical overbite, crowding of 8 mm, open bite meeting the minor criteria, blocked teeth (one blocked cuspid and one blocked bicuspid of by at least 1/3 needed space, and three cuspids blocked by at least 1/4 needed space being the equivalent of the minor criteria of two blocked cuspids per arch). In addition, there has been testimony of negative changes since the initial request through the development of crossbite affecting surrounding tissue. Petitioner has testified that her son bit his palate causing bleeding.

Petitioner has met her burden that her son's condition is as severe as two minor criteria. OVHA's decision to deny comprehensive orthodontic services is reversed. 3 V.S.A. § 3091(d), Fair Hearing Rule No. 17.

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